

The New Kidney Allocation System (KAS)

Frequently Asked Questions

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Frequently Asked Questions

General: The Need for the New System and Key Implementation Details

Why is the newly revised KAS necessary?

The new kidney allocation system (KAS) was developed in response to higher than necessary discard rates of kidneys, variability in access to transplants for candidates who are harder to match due to biologic reasons, and a matching system that results in unrealized life years and high re-transplant rates.

The OPTN Kidney Transplantation Committee (Kidney Committee) spent nearly ten years finalizing the changes, taking into consideration feedback from numerous patient groups, professional transplant societies, individual transplant programs, the 11 OPTN regions, and individuals. Simulation modeling predicts that the new KAS will result in over 9,000¹ additional life years achieved annually from the current pool of deceased donor kidneys.

What are the major changes in the new allocation system?

The new KAS is made of up several major components:

- The current kidney donor quality metric (Standard Criteria Donors or SCD, and Expanded Criteria Donors or ECD) is being replaced with a more refined, continuous metric known as the Kidney Donor Profile Index (KDPI).
- All adult kidney candidates will receive an Expected Post Transplant Survival (EPTS) score. The score is based on four medical factors: age, time on dialysis, current diabetes status, and whether the candidate had a previous solid organ transplant.
- The allocation rules will use the KDPI for donors and the EPTS score for longevity matching between a *portion* of donors and recipients. Those donor kidneys with KDPI 20% or less will first be offered to adult candidates with the top 20% of EPTS scores, followed by candidates with EPTS outside the top 20%.
- Sensitized candidates will be given increased priority through a sliding scale points system for CPRA and regional and national priority for very highly sensitized candidates (those that have CPRA greater than 98%).
- Pre-registration dialysis time will now be included in a candidate's waiting time.
- There are new rules designed to provide greater access to blood type B candidates who can safely accept a kidney from an A₂ (A, non-A₁) or A₂B (AB, non-A₁B) blood type donor.
- In the new system, pediatric priority ("Share 35") will be based on KDPI less than 35%, instead of donors age less than 35 years.
- The payback system is being eliminated, including paybacks for multi-organ offers.
- All variances, other than two that are being incorporated into the new national policy (increased access for blood type B candidates and including pre-registration dialysis time in candidates' waiting time calculation), are being eliminated with implementation of the new system.

¹ Israni, Ajay K., et al. "New National Allocation Policy for Deceased Donor Kidneys in the United States and Possible Effect on Patient Outcomes." *Journal of the American Society of Nephrology* (2014): ASN-2013070784.

When will the new rules for KAS go into effect?

The new allocation rules will become effective December 4, 2014.

On May 27, 2014, UNOS added a number of new data fields to the WaitlistSM application in UNetSM to allow transplant programs approximately six months to update and/or verify candidate data that will be necessary in the new allocation system.

What do transplant programs need to do to prepare for KAS?

There are several steps that kidney transplant programs need to take to prepare for implementation:

1. Communicate to other professionals that early referral for transplantation is still important under the new allocation system.
2. Review patient data elements and confirm, update, or newly report the data. Specifically, programs need to review and/or update candidates' dialysis start date as well as enter the candidate's current diabetes status and number of prior solid organ transplants. Programs are also encouraged to verify the unacceptable antigens listed for each candidate, as well as whether they are listed as having been a prior living organ donor.
3. Review and update candidates' donor acceptance criteria (including the maximum acceptable KDPI and other donor factors each patient will accept).
4. Develop processes for:
 - Obtaining informed written consent from candidates willing to accept kidneys with KDPI greater than 85%;
 - Developing a written protocol regarding titer levels and reporting eligibility for blood type B candidates who may consent to accept a kidney from an A₂ or A₂B donor and obtaining informed written consent from candidates who are willing to accept these offers;
 - Obtaining written approval of unacceptable antigens from the candidate's physician or surgeon and the HLA laboratory director when a candidate's CPRA is greater than 98%, document the approval in candidate's medical record and enter approver names into UNet.

A number of resources and educational materials are available to assist programs with these changes. Refer to the OPTN website (<http://optn.transplant.hrsa.gov>) and TransplantPro (<http://transplantpro.org/kidney-allocation-system/>) often to access these resources. UNetSM also now contains help documentation on all of the data elements.

Waiting Time

How will waiting time be calculated in KAS?

The main change in the new system is that waiting time for adult and pediatric patients will now include time spent after starting dialysis (for the treatment of ESRD) prior to being registered on the waitlist. Like the current system, candidates that haven't started dialysis at time of registration will still begin to accrue waiting time once they are registered on the waiting list *and* have a glomerular filtration rate (GFR) or creatinine clearance (CrCl) value less than or equal to 20 ml/min, or have begun dialysis.

Pediatric candidates will still immediately begin to accrue waiting time upon listing and will receive additional waiting time if dialysis was started prior to listing.

Will waiting time for patients having GFR≤20 ml/min prior to being registered be back-dated similar to dialysis start date?

No. Waiting time will begin for candidates on or after the date of listing with a GFR or CrCl of less than or equal to 20 ml/min.

Now that waiting time includes all pre-registration dialysis time, is there any need for early referral and listing?

Early referral and listing are still very important and the best practice under the new allocation system, since patients with a shorter duration on dialysis prior to transplant tend to have better outcomes. While waiting time is now being calculated to include pre-registration dialysis time, the GFR criterion remains the same. Patients can accrue waiting time points based on this criteria alone. Like the current allocation system, the new system prioritizes zero HLA-ABDR mismatches and patients who are listed early will have access to any such offers, even prior to accumulating significant time on dialysis. It's also important to remember that candidates must be listed prior to their 18th birthday in order to receive pediatric priority.

How do the changes to waiting time affect multiply listed candidates? Will candidates still be able to (or have any need to) transfer primary waiting time?

Primary waiting time transfers will still be permissible. If a candidate began to accrue waiting time based on a GFR/CrCl value prior to starting dialysis, the transfer will still be especially relevant.

If the candidate began to accrue waiting time based on start of dialysis, then the waiting time will be the same at each center (assuming that each center enters the same dialysis start date for the candidate) and a waiting time transfer is less relevant. However, a candidate may still transfer their primary registration date, which will be used in the event of a tie.

Dialysis start date

Will programs now have the ability to edit the dialysis start date for the candidates on their list?

Yes. The dialysis start date (and other waiting time eligibility criteria) is now an editable field on the candidate record in UNetSM. Programs no longer have to submit a work order to UNOS in order to change it.

If a candidate begins dialysis and then stops for a period of time, should I list a dialysis start date?

According to OPTN policy, waiting time points begin to accrue on the date that the candidate began regularly administered dialysis for ESRD. So, if the dialysis was administered for ESRD, the program can list a dialysis start date (documentation of the dialysis start date will be requested). If the dialysis was administered to handle an acute renal issue, that date cannot be used as a dialysis start date.

What dialysis start date should I enter for a candidate who had a prior transplant (the original dialysis start date or most recent)?

Unless the candidate experienced immediate and permanent non-function from the previous transplant, select the date after the most recent transplant. OPTN policy 3.6.B.ii defines immediate and permanent non-function of a transplanted kidney as:

- Kidney graft removal within the first 90 days of transplant

- Kidney graft failure within the first 90 days of transplant with documentation that the candidate is either on dialysis or has CrCl or GFR less than or equal to 20 mL/min

Programs must submit a Renal Waiting Time Reinstatement Form and supporting documentation to UNOS in order for waiting time to be reinstated.

On May 27, 2014, UNet began displaying the CMSSM dialysis start date for programs to reference (if a reliable match could be found based on the candidate's social security number). If I select a dialysis start date that matches the CMS Crown data referenced in UNetSM, do I need to obtain additional documentation for the purpose of UNOS site visits?

No. Site surveyors will not request documentation if the dialysis start date selected matches the CMS Crown data reference displayed in UNetSM.

If the program selects a different date or enters one when no CMS reference date is provided, the program will need to provide documentation supporting this date in the candidate's *medical record* (the list of acceptable documents is the same as those in the current OPTN Evaluation Plan).

Diabetes Status

Can you elaborate on the definition of 'current diagnosis of diabetes'?

UNetSM allows you to select Type I, Type II, or Other Type of Diabetes. If the candidate has any type of induced diabetes or both Type I and Type II diabetes, you should choose Other Type of Diabetes. If the candidate was previously diagnosed with diabetes but the condition was reversed by significant weight loss, gastric bypass surgery, etc., you should choose Does Not Have Diabetes. However, if the candidate was previously diagnosed with diabetes and no longer requires insulin or other diabetic medications (i.e. due to the reduced need for insulin after starting dialysis), you should still indicate a diabetes diagnosis.

The Help Documentation in UNetSM offers further guidance.

If the EPTS score is only influenced according to whether there is a diagnosis of diabetes (yes/no), why does the dropdown in UNetSM ask for the *type* of diabetes?

The Kidney Committee would like to review the data in the future to determine whether the EPTS score should be influenced by the type of diabetes (not simply yes/no). Collecting the data in this way is also consistent with how diabetes status is collected on the Transplant Candidate Registration (TCR) form in TIEDI.

Kidney Donor Profile Index (KDPI)

What is KDPI?

The kidney donor profile index (KDPI) combines 10 donor factors into a single number that summarizes the potential risk of graft failure after kidney transplant. KDPI can help predict how a particular kidney is expected to function relative to other kidneys recovered during the previous calendar year. The KDPI is intended to be a more granular and predictive measure of organ quality compared to the binary ECD/SCD paradigm. Physicians and surgeons should use KDPI in evaluating kidney offers, while also considering other donor characteristics. The KDPI is **not** intended to serve as the only metric for determining donor suitability.

The KDPI ranges from 0% to 100%. Lower KDPI values are associated with higher expected post-transplant longevity, and higher KDPI values are associated with lower expected post-

transplant longevity. KDPI is derived by first calculating the Kidney Donor Risk Index (KDRI) for a deceased donor.

What is KDRI?

The Kidney Donor Risk Index (KDRI) is an estimate of the relative risk of post-transplant kidney graft failure (in an average, adult recipient) from a particular deceased donor compared to the median (50th percentile) donor. A donor with a KDRI of 1.28, for example, confers an estimated risk of kidney graft failure that is 1.28 times that of an “average” donor. Lower KDRI values are associated with a lower inherent risk of kidney failure while higher KDRI values are associated with a higher inherent risk of kidney failure. Multiple donor characteristics are used to calculate the KDRI:

- Age
- Height
- Weight
- Ethnicity
- History of Hypertension
- History of Diabetes
- Cause of Death
- Serum Creatinine
- Hepatitis C Virus (HCV) Status
- Donation after Circulatory Death (DCD) Status

A donor with a KDRI greater than 20% of last year’s recovered kidney donors has a KDPI of 20%.

How do ECD and KDPI differ?

KDPI is a more refined metric for assessing how long a kidney is expected to function, since it takes into account 10 donor factors, compared to ECD which only considers four (age, creatinine, history of hypertension, and cause of death). In addition, the ECD criterion is limited since it is a binary assessment of donor quality, while KDPI estimates donor quality on a continuous scale. Some ECD donors actually have better estimated longevity (per KDPI) than some SCD donors, and vice versa.

Will transplant programs be able to select a different maximum acceptable KDPI for all the patients on their list? Can the criteria be different for local vs. import offers? What about for zero-antigen mismatch offers?

Yes, yes, and yes. Transplant programs will have the ability to set a different maximum KDPI score for each candidate on their list.

Programs will also have the ability to set the maximum KDPI differently for local vs. import offers, just as they can today for maximum age and other donor acceptance criteria. In addition, programs will be able to indicate a different maximum acceptable KDPI for zero-mismatch vs. non-zero mismatch offers. Similar to the current ECD offer screening functionality, programs will actually be able to provide 4 different maximum acceptable KDPI values for each candidate: local, non-0MM; local, 0MM; non-local, non-0MM; non-local, 0MM. For example, a program might choose to set the maximum acceptable KDPI for local, zero-antigen mismatch offers to 100%, but choose to avoid receiving non-local, non-zero mismatch offers of donors with KDPI>80%. Programs will be able to choose maximum KDPI values anywhere along the spectrum from 0% to 100%.

On May 27th 2014, to ease the data entry burden for members, UNetSM automatically set the maximum KDPI values to 100% for already-listed kidney candidates who previously agreed to see offers for ECD kidneys. The maximum KDPI was set to 85% for all remaining candidates. However, transplant programs still have the ability to change the maximum KDPI for all candidates.

On December 4th 2014, UNetSM will set missing maximum KDPI values to 100% for candidates listed as willing to accept an ECD, and to 85% for candidates not listed as willing to accept an ECD. Transplant programs have the ability to subsequently change these values if desired.

How will donor offer screening based on maximum KDPI work, given that transplant centers can also screen offers based on maximum donor age and other factors?

Offer screening will function similarly to how screening based on ECD and other factors works today. Here are a couple of examples in the current versus new system (beginning on December 4th, 2014).

An example of how things work in current system: if a candidate is listed as willing to receive a local ECD offer, but the maximum donor age (local) is set to 55, the candidate will not receive any local offers from donors over the age of 55, regardless of whether the kidney is ECD or not.

An example of how things will work in new system: if a candidate is listed as willing to accept a local kidney with a maximum KDPI of 50%, but the maximum age (local) is set to 45, the candidate will be screened off of all local match runs where donor is over the age of 45, regardless of whether the KDPI is 50% or less.

In other words, the system will screen donor offers (prevent a candidate from appearing on the match) if *any* of the donor parameters do not match the donor criteria selected for the candidate.

Since the KDPI incorporates factors such as donor age, DCD status, serum creatinine, history of diabetes, and history of hypertension that can also be used for offer screening, if a transplant program desires to screen kidney offers for expected longevity by primarily using the KDPI, the program should consider relaxing some or all of the screening parameters that are components of the KDPI. For example, if a candidate has a maximum age value set to 60, but the center is interested in receiving offers from KDPI≤85% donors as long as donor age does not exceed 70, the center may choose to set the maximum KDPI to 85% but increase the maximum age to 70.

Remember that HCV serostatus is only included in the KDPI due to its effect on graft longevity, not due to the potential risk of disease transmission. An HCV positive donor, for example, may still have a low KDPI. Transplant programs must ensure that “Accept an HCV positive donor?” and other acceptance parameters related to donor serologies are set appropriately for each candidate.

Do transplant programs need to obtain written, informed consent from every candidate on their list for the KDPI criteria that each candidate is willing to accept?

No. Transplant programs are only required to obtain written, informed consent for candidates willing to receive offers for kidneys with a KDPI score greater than 85%. If the program has already obtained consent for an ECD kidney on a candidate listed prior to implementation of the new KAS (December 4th, 2014), the program does not need to obtain a new consent. However, transplant programs need to update their consent forms to reference KDPI greater than 85% instead of ECD in preparation for implementation of the new system.

How will dual kidney allocation work in the new system?

The same kidneys that are eligible for dual allocation under the current system will be eligible under the new KAS. Kidneys from donors that meet *at least two* of the following donor criteria are eligible to be allocated to the same patient:

- age > 60
- eCrCl < 65 ml/min based on admission creatinine (Cr)
- rising Cr (> 2.5 mg/dl)
- long-standing hypertension or diabetes
- 15% < glomerulosclerosis < 50%

The dual usage of kidneys has been shown to confer a survival advantage compared to single kidney transplantation. However, in both the current system and new KAS, transplant programs do not have the ability to differentiate donor criteria between dual versus single offers.

Consequently, if a candidate is willing to accept a single kidney with KDPI up to 85%, but is interested in receiving dual kidney offers from a donor with KDPI up to 100%, the transplant program should enter 100% as the maximum acceptable KDPI for that candidate.

EPTS

What is an EPTS score?

The Estimated Post Transplant Survival (EPTS) score is a numerical measure used in the new kidney allocation system to allocate some kidneys in the new kidney allocation system. Every adult patient on the kidney waitlist will receive an EPTS score for use in the new system.

EPTS scores are percentages that range from 0% to 100%. Candidates with a lower EPTS score are expected to experience more years of graft function from high-longevity kidneys compared to candidates with higher EPTS scores.

EPTS values are derived by comparing each candidate's raw EPTS score to percentiles from a reference population consisting of all adult kidney patients on the (national) waitlist as of a recent date.

How will the EPTS score be used in the kidney allocation system?

Beginning on December 4, 2014 the EPTS score will be assigned to all adult kidney candidates on the waiting list. The score is based on four factors: candidate age, length of time on dialysis, prior transplant of any solid organ, and current diabetes status. The EPTS score is designed to achieve better longevity matching. The candidates with the top 20% EPTS scores will receive offers for kidneys from donors with KDPI scores of 20% or less before other candidates at the local, regional, and national levels of distribution. Candidates will not be prioritized based on EPTS for allocation of kidneys from donors with KDPI scores greater than 20%.

Do transplant centers need to take any actions due to the introduction of the EPTS score?

Yes. To calculate the EPTS score, two new data entry fields for candidates have been added to the waitlist: current diabetes status and number of prior solid organ transplants. Transplant programs must provide this information for all of their waitlisted kidney candidates and verify the dialysis start date that is used both to calculate the EPTS score and for determining waiting time points. Electronic data entry tools, including a batch upload facility, have been added to UNetSM to ease the updating of this data. Programs have until December 4th, 2014 to update and verify this data prior to the implementation of the new allocation system.

Additional information about calculating and interpreting EPTS can be found in the “Guide to Calculating and Interpreting the Estimated Post-Transplant (EPTS) Score Used in the Kidney Allocation System (KAS)” document.

Sensitized candidates, CPRA Approvals, Desensitization

How will the new system increase access for sensitized candidates?

Kidney candidates are assigned a Calculated Panel Reactive Antibody (CPRA) score that is based on the unacceptable antigens listed for each candidate. In the current system, candidates receive four additional prioritization points if their CPRA score is equal to or above 80%. In the new allocation system, prioritization points will be assigned based on a sliding scale, beginning with a CPRA score of 20%. Candidates with CPRA of 20% will receive 0.08 points, which is equivalent to about a month of waiting time. Candidate with CPRA of 75-79% will receive 1.58 points, and those with CPRA 80-84% will receive 2.46 points. Candidates with CPRA of 98%, 99%, or 100% will receive 24.4, 50.09, and 202.10 points, respectively.

However, the Kidney Committee determined through statistical simulation modeling that points alone would be insufficient for increasing access to candidates that are extremely difficult to match. Consequently, candidates with CPRA of 98%, 99%, or 100% will also receive local, regional, and national priority, respectively, in addition to the large number of priority points.

In addition to improving access for sensitized candidates, these changes are intended to incentivize programs to enter all unacceptable antigens for their candidates. The Kidney Committee anticipates that these changes will help decrease the likelihood of unexpected positive crossmatches on kidneys shared regionally and nationally and, therefore, increase efficiency in the overall allocation system.

Programs should review the unacceptable antigens reported for sensitized candidates to determine whether all unacceptable antigens have been reported. This will ensure that

candidates receive their full prioritization points and will decrease the chance that candidates will receive incompatible offers.

What allocation sequence is used if a kidney is shipped regionally or nationally to a highly sensitized candidate and the intended recipient cannot be transplanted?

Per OPTN Policy 5.7 *Released Organs*, the transplant program must release the organ back to the host (originating) OPO. The host OPO may allocate the kidney according to its own match or delegate allocation to the importing OPO. Similarly, the host OPO can backup the organ offer according to its match list prior to shipping the kidney or allow the importing OPO to back up the offer according to its match sequence. The decision lies with the host OPO.

Why does the new policy require the candidate's physician or surgeon and the HLA laboratory director to review and sign a written approval of the unacceptable antigens for candidates with CPRA greater than 98%?

The Kidney Committee required the review as a way to ensure accuracy in the unacceptable antigens listed for these candidates, since they will have access to kidneys shipped regionally and nationally.

What is the process for obtaining written approval for candidates with CPRA greater than 98% in order to receive regional or national prioritization? Can the candidate's physician or surgeon and the HLA laboratory director assign a designee to provide approvals?

This is a multiple step process:

1. The candidate's physician or surgeon and the HLA laboratory director must review the unacceptable antigens listed.
2. Written approval from both individuals must be documented in the candidate's medical record along with the unacceptable antigens that are approved. Electronic signatures are permissible as long as they are provided consistent with the hospital's internal policies for electronic signatures.
3. The approver names must be manually entered into UNetSM so that the system will recognize that the candidate is eligible for regional or national sharing.

Once both approvers have reviewed and provided signatures in the candidate's medical record, the transplant program can designate other individuals to enter the names of the approvers into UNetSM.

Are the written approvals required every time the unacceptable antigens change? What if a candidate's CPRA fluctuates below and above 98%?

No. The approval process outlined above is only required once.

Once both names are entered, the system will recognize the additional sharing priority even if the CPRA fluctuates below 98% and then above again. The system will not prompt you to enter the names a second time.

What happens if one or both signatures is missing on December 4, 2014?

If one or both approver names are missing, the candidate will still be eligible for offers and will still receive prioritization points based on the sliding scale CPRA.

However, the system will not provide the candidate with regional or national priority.

Are there any changes to CPRA prioritization for patients undergoing desensitization?

No. However, the OPTN/UNOS Kidney Transplantation and Histocompatibility Committees are discussing the issue and considering whether to recommend a policy change that would allow patients undergoing desensitization to keep their CPRA prioritization points (even while some unacceptable antigens are removed) for a period of time.

Will OPOs be able to report donor HLA information for DQA or DPB?

Currently, UNetSM does not display fields to report HLA-DQA or HLA-DPB on deceased kidney donors. The Histocompatibility Committee is recommending that this information be required for deceased kidney donors. The OPTN/UNOS Board of Directors will consider this recommendation at the November 2014 meeting. Even if approved, the fields will not become available until after implementation of KAS on December 4, 2014.

OPOs do have the option of uploading an attachment (e.g., .pdf file) in DonorNet® to communicate additional donor antigens until the fields are available.

Increased Access for Blood Type B Candidates (A₂/A₂B eligibility)

Candidates with blood type B who meet certain criteria will receive offers from donors with blood type A₂ (A, non-A₁) or A₂B (AB, non-A₁B). What do transplant programs need to do to in order to receive these offers?

Blood type B candidates who meet their program's clinical criteria for titer levels will be eligible to accept kidneys from donors with blood type A₂ or A₂B. Programs will need to develop a written protocol for patient eligibility, selecting a maximum titer level for candidates in this category.

Programs will also need to obtain written informed consent from each blood typed B candidate willing to accept a blood type A₂ or A₂B kidney before reporting the candidate as eligible in the system. Programs will be required to confirm in UNetSM every 90 days that the candidate is still eligible according to the program's protocol to accept these offers. However, the only confirmation needed is a "yes" or "no" for eligibility; there is no requirement to report the titer values in the new system. UNetSM will display the number of days remaining before the next confirmation is needed.

Though centers can indicate and reconfirm candidate eligibility, that eligibility won't be applicable until implementation of the new KAS. The system will display due date to reconfirm eligibility and an A₂/A₂B eligibility report is available in UNet to help centers keep track of candidates' eligibility status and expiration dates. Programs interested in receiving A₂ or A₂B offers for qualifying blood type B candidates should make sure that candidates' eligibility is current at the time of implementation.

Will blood type B candidates listed at programs currently participating in the national variance be automatically eligible to receive offers from donors with blood type A₂ (A, non-A₁) or A₂B (AB, non-A₁B) on December 4, 2014?

No. Candidates eligible under current system will not be assumed to be eligible under new KAS. In order for them to be eligible under KAS, transplant programs will need indicate their eligibility using the new eligibility fields (add to WaitlistSM on May 27, 2014) and reconfirm eligibility in the system every 90 days.

Pediatric Candidates

If a candidate is listed after their 18th birthday, but their dialysis start date is before their 18th birthday, does the candidate still receive pediatric priority?

No. The dialysis start date is used for assessing waiting time points and as a factor for the EPTS score. The new policy 8.4.B specifies that the candidate must have been listed prior to their 18th birthday to receive pediatric priority.

Additional priority for prior living organ donors

Do prior living donors receive additional priority under KAS?

Yes. As in the current system, prior living donors will continue to receive four additional prioritization points with every listing (for second or additional transplants).

If a patient has donated a kidney, liver segment, lung segment, partial pancreas, or small bowel within the U.S. or its territories, he or she is qualified to receive the four points. The name and hospital of the recipient and date of organ procurement must first be reported to the OPTN Contractor before four points are awarded.

Local, State, and National Variances

When will the Kidney Committee consider new allocation policy variances?

The Committee will need to allow some time to pass after the policy is fully operational in order to establish a baseline from which to assess any new variance. The Committee has decided that no variances will be considered until the policy has been operational for at least one year.

Geography

Is the new allocation system expected to have any impact on reducing geographic disparities?

Some of the changes are expected to have an impact on geographic disparities. For example, kidneys are expected to be allocated outside of the local DSA more frequently due to regional and national priority for very high CPRA patients, as well as the use of a combined local/regional list for allocation of KDPI>85% kidneys.

However, the Committee recognizes that substantial geographic disparities will continue to exist, since addressing this issue was not a primary goal of the new system. The Committee is currently discussing changes to address geographic disparity, including defining one or more metrics to assess disparities in deceased donor kidney allocation.